mahp MASSACHUSETTS ASSOCIATION of HEALTH PLANS

December 30, 2002

The Honorable Nancy Flavin
State House Room 238
Boston, MA 02113

Re: Massachusetts Association of Health Plans comments on LECG Final Report of December 17, 2002 on the Feasibility of Consolidated Health Care Financing and Streamlined Health Care Delivery in Massachusetts

Dear Representative Flavin:

As a member of the Advisory Committee on Consolidated Health Care Financing, the Massachusetts Association of Health Plans again congratulates you on the completion of this report and for your management of a challenging and difficult process. MAHP continues to believe that an incremental approach to achieving universal coverage makes the most sense in the current political and economic environment and in that context we believe that Medicaid expansion is the most viable option of the three presented in the report.

Our members do have several comments on the final report, which are listed below:

P.101. Commentary on the Canadian System- The report does mention some of the problems of the Canadian system and analogizes it to the "ongoing difficulties of many low-income, uninsured U.S. citizens who are forced to access care via emergency rooms and relatively high-cost urgent care centers." However, this "inconvenience" of waiting lists and discontinuance of services when funds run out is very unlike the experience and expectations of the vast majority of citizens of Massachusetts, who do have health insurance. Only 6.26% of the citizens of the Commonwealth are uninsured. A Canadian-type system would be very disruptive for the vast majority of people in the Commonwealth.

P.108. Global Budgeting- The report states that "Members of the Advisory Committee voiced support for global budgeting..." We and other members of the committee voiced our opposition to global budgeting in meetings and in correspondence and asked that this wording be changed in the final report. It was changed in the Executive Summary on page 16, where it states that "Some members of the Advisory Committee voiced support for global budgeting...." The language on page 108 should read the same way as it does on page 16 to accurately reflect the differing views on this issue. Footnote 79 does not accomplish this.

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P.111. Closed Formularies- The report indicates that the new system would likely use "a closed formulary like large insurers and managed care organizations currently use. LECG estimates that a formulary would result in administrative costs and savings similar to those found in managed care." While they are still used, closed formularies are no longer the most frequently chosen model. Tiered formularies are now the norm. We are not sure if this affects the modeling or savings anticipated, to say nothing of the potential dissatisfaction with the impact of closed formularies for the majority of people who have grown used to open formularies.

P.117. Quality of care- The report states that "There is no reason to speculate that the average quality of care in the single payer model will vary much from today....
- Similarly, those individuals who receive the best care today may experience lower quality care in terms of greater waiting time for services, less choice of provider and, in the event of catastrophic need, less sophisticated quadriary services than they have access to today."

We believe that this commentary greatly understates the magnitude of the decline in quality of care for the vast majority of residents, given current expectations of those who have coverage. Most residents of Massachusetts have excellent coverage, with only 6.26% without coverage. This means that most people will have a lower quality of care, to accommodate the needs of a relatively small portion of the population. Even those whose care is currently paid for by the government, state employees and Mass Health, are not accustomed to the kinds of waiting times and disruption in care that occur routinely in places such as Canada. In this context, it is more accurate to conclude that the "average" quality of care, as perceived by the majority of people, will decline.

P.118. Impact on the insurance and managed care industry- The report mentions the labor force disruption in the private insurance markets but indicates that it cannot quantify that impact. The managed care health plan and insurer industry in Massachusetts is consistently ranked among the best in the nation and is a major employer in the state. To us, it is a major flaw in the report that it does not address the loss of that quality delivery of services and cannot quantify the loss of jobs in this critical sector of the Massachusetts economy.

P.119. Implementation issues- The report continues to ignore the implications of instituting a single payer system in one state, which still must participate in a national economy and in the context of different federal regulation of its health care delivery system.

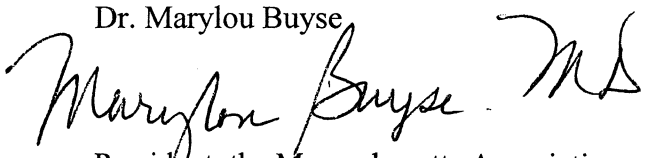
The report does not consider the political and economic implications of the creation of a health care budget of between $ 44 billion and $48 billion in a state that currently has a $23 billion overall budget that it struggles to manage effectively. We find nothing in the report that will cause the disappearance of the never ending political debates that affect the development of rational budgets? One need only look to Canada to see how disruptive this political process is and how dangerous the consequences can be.

The report fails to acknowledge that business, which will ultimately shoulder so much of the tax burden of this $44 to $48 billion dollar expense, can vote with its feet and its moving vans if it concludes that it is tired of paying for a health care system where too many people receive full benefits while never paying a dime to support the system. While health insurance is a big expense for large business now, it is an expense that they can control, through benefit design, eligibility and the size of their workforce. It can be adjusted to meet the needs of the national or international marketplaces in which they must compete. The money is spent for the benefit of their own employees and they can insist on quality initiatives and improvements. All of this control is lost in a single payer system. As an example, the high tech industry, which is so critical to the Massachusetts economy, can easily move its people to other states to avoid these taxes. Unlike factories of old, computers can be moved very quickly to another state and be up and running in days or the work can simply be sent elsewhere, leaving that company's employees in Massachusetts unemployed.

To the extent the state is forced to make increasing use of its "monopsony power in the market"(p. 118) to limit provider compensation, it is entirely possible that Massachusetts could see a migration out of the state of the high quality providers for which it is currently known. If businesses leave the state, shrinking the tax base that supports the system, the state may be forced to cut back on reimbursement as the only way to control an ever growing budget to support health care. Providers would have no opportunity to cost shift to private payers. A single state doing this will create an open invitation for many providers to move their practices or facilities to other states if they think they have a better opportunity to make a living in the private marketplace that will still exist in those other states. A shrinking tax base, a loss of quality providers, a lack of private incentive to do research and development because it will not be supported by the state, and an ever growing population of non-taxpayers seeking "free care" sounds like a formula for disaster.

MAHP continues to believe that an incremental approach to universal coverage makes the most political and economic sense and we continue to oppose a single payer system.

Dr. Marylou Buyse



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Cc: J. Gaisford